month period were determined from a claims database. Data were analyzed using Pearson correlation coefficients.
RESULTS: Results of the interim analysis in 150 respondents (64 adults, 86 children) indicate that patient-assessed severity had a stronger correlation with DLQI ($r = 0.43$, $p = 0.0004$) and CDLQI ($r = 0.42$, $p = 0.0011$) than did retrospectively assessed severity ($r = 0.39$, $p = 0.0015$ [DLQI]; and $r = 0.10$, $p = 0.44$ [CDLQI]). Among the eight domains reported in the SF-36, the DLQI showed the strongest correlation with the mental health domain ($r = -0.57$, $p = 0.0001$). Visit counts were significantly correlated with self-assessed severity for adults ($r = 0.40$) and children ($r = 0.32$).
CONCLUSIONS: A weaker correlation for QOL and physician visits was observed with retrospectively assessed severity than with patient-assessed severity. Self-assessed severity of illness correlated moderately well with QOL and number of physician encounters.

MGB5

ADHERENCE OF HEALTH CARE WORKERS TO HEPATITIS B VACCINATION (HBV) POLICY IS INFLUENCED BY LEADERSHIP

Sutton EL
Department of Defense Pharmacoeconomic Center, Fort Sam Houston, TX, USA

Although OSHA regulations require that HBV be made available to health care workers (HCW), the participation rate with the HBV policy is low. Previous studies address characteristics of non-adhering HCW but do not use this information to subsequently develop organizational strategies to increase adherence rates.
OBJECTIVE: Determine the vaccination rates of all high-risk HCW to a HBV policy and to evaluate the effect of leadership in improving those rates at a military hospital.
METHODS: 118 HCW at high risk for hepatitis B were categorized by selected variables. Univariate analysis assessed the significance of differences between HBV status and the selected variables. A conditional probability model evaluated the response to HBV policy and subsequent organizational leadership actions to improve vaccination rates.
RESULTS: Only 61% and 56% of the military and civilian HCW had initiated the HBV series; however, 100% of the housekeepers completed the series. If a supervisor had the HBV, the Odds Ratio that the HCW had the HBV was 8.3 (95% CI 3.3, 21.1). The military HCW completion rate was increased with passive then active leadership to 85% then 100%. The civilian HCW completion rate was increased to 70% then 93%, with passive then active leadership actions during a six-month follow-up observation period. Surprisingly, directed education and worksite availability had no effect on the nursing group. Leading reasons for civilian nurses initially declining HBV were pregnancy/nursing (36%), needle phobia (28%), no knowledge of availability (21%), no time (7%), and no risk perception (7%).
CONCLUSION: Policy alone will not lead to acceptable HBV rates among HCW. Acceptable rates are achievable with both combined passive and active organizational leadership techniques.

MGB6

FORMULARY IMPACT DECISION MODELING IN HMG-COA REDUCTASE INHIBITORS

Corey R, Sung JCY
Novartis Pharmaceuticals Corp., East Hanover, NJ, USA

According to the NHANES III data, a majority of patients require 20–30% reduction in their LDL-cholesterol to achieve their NCEP goal. Fluvastatin, a HMG-CoA reductase inhibitor (statin), has been shown to be both safe and effective in achieving 20–30% reductions in LDL-cholesterol, and of all the statins, it has the lowest drug acquisition cost.
OBJECTIVE: The purpose of this model was to assess the economic impact of using a two-drug formulary that includes fluvastatin and another statin, versus a one-statin formulary.
METHODS: In a hypothetical cohort of 10,000 patients, a two-drug formulary with fluvastatin as the statin of choice for mild to moderate LDL-cholesterol reduction and another agent for those patients requiring additional reduction was compared with a one-drug formulary of atorvastatin, pravastatin, or simvastatin. NHANES III data was utilized to estimate the percentage of patients requiring $<30\%$ or $\geq 30\%$ LDL-cholesterol reduction. Doses used in this model were the average daily doses required for adequate LDL reduction as estimated by 1997 IMS data, and costs of drug therapy using a weighted AWP. The cost savings was estimated by subtracting the combined drug acquisition costs of the two statins from the cost of a single statin prescribed for 100% of the patients. Sensitivity analyses were also performed on key parameters of the model.
RESULTS: Based on NHANES III estimation, over 70% of patients would require a $<30\%$ LDL-cholesterol reduction. A two-drug formulary using fluvastatin was shown to provide more cost savings than a single-drug formulary using any of the other agents, with annual cost difference ranging from $1.2 million to $3 million per 10,000 patients.
CONCLUSIONS: Using formulary modeling, managed care decision-makers can measure the economic impact of their statin choice. This model demonstrates the economic benefit of using fluvastatin in formulary management.